Integra Partners
P: 1-888-729-8818
F: 1 248-844-3824

Neighborhood Health Plan of Rhode Island (NHPRI): DME Authorization Form

DATE: ____________________

PRIORITY:

☐ **Expedited Request** ☐ Hospital Discharge/SNF

*** By checking Expedited Request, you are stating that processing this request in the Standard time (14 days) for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

☐ **Retro Request** Date Member was serviced? ____________________

☐ **Extension Request**

☐ **Continuity of care**

MEMBER INFORMATION

Member Last Name:____________________ Member First Name:____________________

Member DOB:____________________ NHPRI Member ID #: ____________________

Does Member have Other Primary Insurance? ☐ Yes ☐ No If so, please indicate type:____________________

PROVIDER INFORMATION

Servicing Provider Name: ____________________ Provider NPI: ____________________

Provider Telephone: ____________________Provider Fax: ____________________

Provider Address: ____________________

Requesting Physician Name:____________________ Physician NPI: ____________________

SERVICE INFORMATION

Primary Diagnosis (ICD10)____________________Secondary Diagnosis____________________

Service Start Date MM/DD/CCYY	**Service End Date** MM/DD/CCYY	**Item** (HCPCS)	**Item Description** (For NOC, include Manufacturer & Model #)	Rental **(RR)** Purchase **(NU)**	**Quantity** (Per month for supplies)	**Pricing** (FOR MISC/NOC ONLY)	**Comments:** To be completed by Integra UM

*** Invoice/MSRP required for all pricing of miscellaneous (MISC) and not otherwise classified (NOC) HCPCS codes, all other codes will be paid per contractual fee schedule or SCA.

Authorization Number: ____________________UMC Initials: ____________

If your date of service range changes, you must call (866) 205-2122 and have the date of service changed prior to claims submission.

Member Last Name: ____ Member First Name: _____________________________________

Member DOB: _____________________________________ NHPRI Member ID #: ____

SERVICE INFORMATION (CONTI.)

Service Start Date MM/DD/CCYY	Service End Date MM/DD/CCYY	Item (HCPCS)	Item Description (For NOC, include Manufacturer & Model #)	Rental (RR) Purchase (NU)	Quantity (Per month for supplies)	Pricing (FOR MISC/NOC ONLY)	Comments: To be completed by Integra UM

Provider notes: (Please indicate if this request is for a single case agreement, auth extension, quantity/code change, and/or over quantity)

*** Invoice/MSRP required for all pricing of miscellaneous (MISC) and not otherwise classified (NOC) HCPCS codes, all other codes will be paid per contractual fee schedule or SCA.

Authorization Number: ____UMC Initials: ____________

If your date of service range changes, you must call (866) 205-2122 and have the date of service changed prior to claims submission.